

**State Employee Benefits Committee  
Tatnall Building, Room 112  
Dover, Delaware 19904**

The State Employee Benefits Committee met April 10, 2017. The following people were in attendance:

**Committee Members:**

Mike Jackson, Director, OMB  
Deloris Hayes-Arrington, Designee of Secretary of Finance  
Omar Masood, Designee of the Treasurer  
Mike Morton, Controller General  
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts  
Stuart Snyder, Designee of the Insurance Commissioner  
Kara Walker, Secretary, DHSS  
Keith Warren, Designee of the Lt. Governor

**Guests:**

Brenda Lakeman, Director, SBO  
Faith Rentz, Deputy Director, SBO  
Lisa Porter, SBO  
Andrew Kerber, DOJ  
Matt Bittle, DE State News  
Jennifer Bredemeier, Univ of DE  
Ronald Burrows, DRSPA  
Lisa Carmean, City of Milford  
David Craik, Pension Office

**Guests (continued):**

Jacqueline Faulcon, DRSPA  
Karin Faulhaber, PHRST  
Judy Grant, HMS  
Regina Mitchell, OMB  
Bill Oberle, DSTA  
Karol Powers-Case, DRSPA  
Dr. George Schreppler, DCSN  
Jeff Taschner, DSEA  
Jim Testerman, DSEA-R  
  
Mike North, Aetna  
Shari Sack, Aflac  
Wendy Beck, Highmark  
Jennifer Mossman, Highmark  
Walt Mateja, Truven Consulting  
Kevin Fyock, Willis Towers Watson  
Chris Giovannello, Willis Towers Watson  
Jaclyn Iglesias, Willis Towers Watson  
Rebecca Warnken, Willis Towers Watson

**Introductions/Sign In**

Director Jackson called the meeting to order at 2:00 p.m. with the announcement that Jeff Taschner, DSEA will be joining the SEBC Committee members once appointed by the Governor. Introductions were made.

**Approval of Minutes** - handout

The Director requested a motion to approve the minutes from the March 24<sup>th</sup> SEBC meeting. Controller General Morton made the motion and Secretary Walker seconded the motion. The motion carried.

**Director's Report** – Brenda Lakeman, Statewide Benefits Office (SBO)

**Open Enrollment (OE) Updates:**

- On April 4<sup>th</sup>, the 2017 Open Enrollment (OE) Curriculum of short, informational mini-videos were assigned to all benefit eligible State and school employees. Within less than a week, 227 agency employees completed the curriculum out of 14,351 employees; 715 school employees completed the curriculum out of 14,859; and 55 completed the curriculum from the separate website for participating groups.
- A fair amount viewed the optional videos consisting of the health plans, Spousal Coordination of Benefits (SCOB) Dependent Coordination of Benefits (DCOB) and the myBenefitsMentor tool.
- Postcards were mailed April 5<sup>th</sup> announcing OE.
- Posters promoting employee education sessions and health fairs will be sent to the State agencies and schools.
- Aetna and Highmark are also advertising.
- SBO has received some calls with questions on difference between the Highmark and Aetna CDH and HMO plans.
- The on-site/near-site clinic request for information was posted on April 3<sup>rd</sup> with responses due April 24<sup>th</sup>. The feasibility analysis due to present to SEBC in June.

**FY18 GHIP Planning** - handout - Willis Tower Watson (WTW)

Three main categories include member cost sharing considerations for January 1, 2018, Centers of Excellence (COE) and incentive approaches. The Background overview shows opportunities to achieve the goals of the GHIP's strategic framework by increasing member cost sharing and plan design changes by:

- Increasing active and pre-65 retiree premium cost sharing by 1%, 2% and 3%
- Eliminating the Special Medicfill contribution inequity
- Adding deductibles (ranging from \$50/\$100 single/family to \$500/\$1,000) to HMO and PPO plans
- Adding deductibles and/or copays to the Medicfill plan

The premium cost share savings associated with 1%, 2% and 3% increases were shown broken out by funding source with the impact on general fund and overall view for a six month period. Current active/pre-65 retiree premium cost share is 10.6% which is significantly low compared to the benchmark study of 22.2% for general industry and 20% for education and government/public sector. States savings with each increase shift was shared along with a uniform increase across all plans showing employee/pensioner impact. Plan contributions with financial difference for a per month basis ranges were illustrated. Ms. Nestlerode expressed concern as employee's salaries have remained stagnant for the last ten years with no salary plan in sight and requested an analysis of how much of a pay cut this would be for employees. Dr. Walker agreed and added the need to steer choices from PPO to much more patient friendly, patient centered plans to help members make appropriate health care choices. Director Jackson conveyed this is one option to promote consumerism and acknowledged this indirectly affects the take home salary for an employee yet at the same time helps to educate employees on the best plan for themselves and family as the long term forecast and projection remains.

FY18 and GHIP savings associated with adding deductibles to the HMO and PPO plans were viewed. Savings from adding deductibles are partially offset by a reduction in premium revenue. Distributions of the plans were estimated at PPO-50%, HMO-45% and remaining 5%-FSB and CDH plans. Detail was requested of enrollment by school districts and local agencies as well as a benchmark for education and government/public sector for surrounding states along with the range, including the high range set for public sector for comparisons with salaries. Director Jackson reminded the committee the financial general fund investments in the GHIP has limited funds available for pay policy over the last few years.

Scenarios for each deductible amount were presented for a six month period followed by the plan rates with the financial difference for employees. WTW estimated 10-15% may migrate to the CDH with the \$1,250 Health Reimbursement Account due to HMO/PPO increases and use of the myBenefitsMentor tool. Ms. Warnken stated there has been discussion on moving the program more towards pricing equity, having a fixed dollar subsidy across each plan. The bigger impact to the member will be the deductible. WTW was asked to illustrate salary banded contributions to address the difference in premium contribution or deductibles based on income level. SBO has modeled premium contributions in the past but not for deductibles which would be administratively burdensome to accommodate the numerous plans for the different pay levels.

A potential opportunity to achieve an incremental savings is to eliminate the contribution inequity for pensioners eligible for Medicare that retired prior to July 1, 2012 and require these pensioners to pay a 5% cost share of the Medicfill plan premium to yield \$2.8M savings for a six month period for FY18. As of January 2017, there were 21,262 pensioners enrolled in Medicfill paying \$0 contributions. Dr. Walker asked about the percent of contributions from neighboring states for this pensioner age group. Examples of how the State can achieve savings through increased cost sharing for the Medicfill plan through deductibles and/or copays on specific services were provided.

Traditional mechanisms for managing prescription drug cost (Rx) and utilization in commercial populations are not available to plan sponsors with an EGWP/Medicare Part D population. Express Scripts (ESI) developed a new formulary tier available to the State's EGWP population for Non-Preferred Drugs (NPD) with 830 national drug codes approved by CMS for non-preferred tier. ESI has modeled the savings to the State with \$153,000 for the first year. Member impact modeling to be provided by ESI. An illustration of the non-preferred tier was shared showing the State's current design against the ESI model with the cost shift to members.

With an increased cost share of 1%, this would not yield substantial migration among the plan options. Ms. Lakeman shared from previous years when premiums increased significantly for employees, there were some migration but not significant. When the rate structure was set up in 2012, did see some movement from the PPO due to higher

contributions. Dr. Walker added a real choice like the details on Medicfill non-preferred generics creates conversation between members and their doctors to maybe change a prescription medication and this is a great opportunity to steer people to better care. Mr. Fyock shared in cases when utilizing a decision support tool like myBenefitsMentor, they do see movement into plans that are going to encourage healthier behaviors and may see movement outside of the PPO.

Ms. Iglesias presented the Centers of Excellence (COE) opportunities with a view of the high performance networks as this continues to grow. Aetna and Highmark both designate certain facilities within their provider networks as COEs which are defined to have high levels of quality, cost efficiency, and superior outcomes when performing certain procedures. The availability of COEs through Aetna and Highmark in-network are within a 90-minute drive of each Delaware County. Despite access lacking in Sussex County within a 90-minute drive, there are other in-network facilities available with high quality that are not in the COE network. There is ample access to steer members to these COE facilities that even stretch into neighboring states. TPAs can encourage use of COEs with a number of plan design options such as waiving deductibles for a member choosing to use COE facility or an additional copay for use of a non-COE. The current GHIP plan design does show incentives for use of COEs versus a non-participating COE provider. An enhancement to encourage additional COE use is a travel and lodging benefit which is offered by both TPAs today for transplants but there are other specialty care areas where this benefit could be applied.

Considerations for the SEBC regarding COE include:

- Retain benefit differential for Bariatric and Transplants at COEs and non-COE
- Creating similar benefit differentials between COEs and non-COE for Cardia procedures
- Waiving or reducing member cost share for COE utilization in other specialty areas
- Continue communication with members on the benefits of selecting a COE
- Retain existing travel and lodging benefit to transplant patients
- Expand travel and lodging benefit to users of COEs in other specialty areas

Ms. Nestlerode expressed the Chief Justice's interest to see a hard steerage toward COE providers. Ms. Iglesias continued with there is no cost to the State to implement these considerations. COEs would be processed as in-network with non-COE as out-of-network. Example if coinsurance today is 80%, could make it 90% with utilization of a COE as an incentive. A disincentive is using another facility so the coinsurance would drop to lower than 80%. Cost savings may be less on contracted rates and more on the superior quality and lack of complications that come with utilizing a non-COE provider or system for a complex surgery or cancer care. Both TPAs currently maintain a list of COEs, periodically review the quality of clinical outcomes and make assessments.

Ms. Rentz advised the committee if moving towards contracting exclusivity with certain facilities, and the TPA determines that facility remains in that status, would need to account for situations if the facility fell out of status and no longer a Blue Distinction Center or COE. A contingency plan would need to be put in place. Director added the savings would be ultimately what changes the trend and bending the curve for the future. By making it a requirement to utilize a COE provider along with other incentives to drive engagement, this is an opportunity for GHIP to steer members to these high quality providers which is in their best interest for this specialty care.

Health incentives with information from WTW's surveys focused on the U.S. was viewed. Participation remains low with about 60% earning some level of incentives while 40% didn't earn anything. Employer interest in incentives remains strong and report they expect incentive systems to change significantly. A high growth in progress-based outcomes that measure and reward individuals for making progress toward a healthy lifestyle. Disincentives such as tobacco surcharges penalize based on tobacco-use status. WTW did research around a dollar amount incentive and what the right amount is depends on the incentive. Ms. Hayes-Arrington expressed concern how this could adversely impact certain protected classes as research shows certain minority classes were pre-dispositioned for diabetes or high blood pressure. Past DelaWell participation with a \$100 to \$200 incentive awards was less than 20%. Further analysis is needed to determine the appropriate incentive award for the State's population. Dr. Walker shared the idea of having an incentive package that would offset the increases to members. Potential incentives for SEBC to consider were reviewed. Incentives in combination with COE and other items anticipate a 2% reduction in trend.

Demographics around the current employee average age, gender, who is selecting what plan, chronic conditions is included with the Quarterly reporting provided by WTW and it was noted that compensation and cost sharing from surrounding State's would be beneficial to view.

Dr. Walker added it would be helpful to see a mock-up illustrating the impact of different deductibles on employees at various income levels, particularly lower income and eventually how potential incentives might serve to offset the impact of plan design or premium increases. Incentives could include use of COEs to offset increases. Continued use of price transparency, consumerism tools and alternative care such as Telemedicine were encouraged. WTW will work to provide follow-up on the questions discussed today.

#### **Public Comments**

Ms. Karol Powers-Case, DRSPA shared her concern about the Medicare retirees with the copays presented in having multiple doctors, current income and the high price of prescriptions which may cause this population to stop seeing doctors or taking their prescriptions and asked SEBC to consider this population in any changes of the copays and premiums.

Bill Oberle, DSTA, shared on-site facilities along with the COE can be a good mechanism to bend the cost curve. Supporting evidence from Aetna shows the State is paying 30% higher for medical care compared to other states.

Jeff Taschner, DSEA, added the Health Plan Task Force was informed the State pays 25% to 30% more for hospital costs than comparable markets. Before shifting costs to employees and retirees, we have an obligation to use findings of the Health Plan Task Force rendered in December 2015. If we can achieve some of those savings, the \$6.5M needed will come pretty quick. Also need to look at the other findings of the Health Plan Task Force and new SEBC members should review the final report. We need more information on the average pension benefit before 2012 as this annual income received is really small, and when hit with more copays, it will be a huge impact.

Director Jackson stated that some of these issues are within the committee's reach where other items are outside the scope of this committee. With certain known facts and forecasts, there is a need to look at cost sharing arrangements across the entire state and continue to engage members.

#### **Other Business**

None

#### **Motions**

None

Director Jackson announced the next meeting is scheduled for Friday, April 21<sup>st</sup>. The Director then requested a motion to adjourn the meeting. Controller General Morton made the motion and Dr. Walker seconded the motion. Meeting adjourned at 3:45 pm.

Respectfully submitted,

Lisa Porter  
Statewide Benefits Office